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| LORIAN HOME SYSTEMS INC OF LAS VEGAS | 3130 SOUTH RAINBOW BLVD SUITE 301 LAS VEGAS, NV 89146 |

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| G 000 | INITIAL COMMENTS<br><br>This Statement of Deficiencies was generated as a result of a Medicare recertification survey conducted at your agency on January 27, 2010 through February 3, 2010 in accordance with 42 CFR Part 484 - Home Health Services.<br><br>The active census at the time of the survey was 86. Fifteen (15) clinical records were reviewed. Five (5) home visits were conducted.<br><br>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.<br><br>The following regulatory deficiencies were identified: | G 000 | | |
| G 144 | 484.14(g) COORDINATION OF PATIENT SERVICES<br><br>The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur.<br><br>This STANDARD is not met as evidenced by:<br>Based on interview and record review, the agency failed to ensure documentation in the patient's record showed effective care coordination for one of 15 patients (Patient #12).<br><br>Findings include: | G 144 | | 3/31/10 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| G 144 | Continued From page 1<br>Patient #12<br><br>Patient #12's record was reviewed on 2/3/10. The patient was admitted to the agency on 10/7/09, with diagnoses including abnormality of gait, Alzheimer's disease, and lung cancer. For the certification period of December 6, 2009 through February 3, 2010, the physician ordered the services of the Skilled Nurse (SN) for wound care to a newly developed wound, Physical Therapist (PT), and Occupational Therapist (OT),<br><br>On 1/15/10, the agency held a case conference regarding Patient #12. All the disciplines involved in the patient's care signed the back of the case conference form. The front of the form had preprinted areas for each discipline with preprinted problems. Under SN the problems of "medication teaching/unreliable with meds; disease process teaching; and, wound/healing process/tx (treatment) administration" were checked. There was no documentation on the form for the checked areas to explain what the SN had discussed regarding Patient #12 for those problems. For PT, the problems of "difficulty with transfers; difficulty with gait; poor safety awareness/balance; and, decreased ROM (range of motion)/strength" were checked. There was no documentation on the form for the checked areas to explain what the disciplines had discussed in regards to those problems. For OT, the problems of "difficulty with ADL's (activities of daily living); decreased ROM/strength; and, decreased fine/gross motor skills" were checked. There was no documentation on the form for the checked areas to explain what the disciplines had discussed in regards to those problems.<br><br>A review of Patient #12's nursing notes indicated | G 144 | | |

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| G 144 | Continued From page 2<br>the wound was slowly healing. A review of the PT notes showed Patient #12 had achieved the goals of therapy and the patient was discharged from PT services on 1/2/10. A review of the OT notes indicated some progress by patient #12 toward therapy goals. This information was not documented on the case conference note.<br><br>An interview was held with the Administrator on 2/3/10, at 1:45 p.m. The Administrator stated at case conferences each discipline summarized their treatment of the patient and the patient's responds to the treatment, the patient's progress toward the goals of treatment, and any problems or concerns noted by each discipline. The Administrator stated a summary of the discussion should be documented on the case conference form.<br><br>The agency's undated policy titled "C-360 Coordination of Patient Services" read, "6. Ongoing care conferences shall be conducted to evaluate the patient's status and progress. For each conference, discussion will include, but shall not be limited to, the following:<br>A. Physical status of patient<br>B. Clinical implications of diagnosis and treatment prescribed<br>C. New/changed medications<br>D. Changes in condition since last conference<br>E. New/changed interventions for all disciplines (including changes in frequency/duration of visits<br>F. Justification for continued services<br>G. Progress towards goals<br>H. Teaching plan and its effectiveness."<br>The policy further stated, "Care conferences will be documented on the Care Conference Summary Form." | G 144 | | |
| G 158 | 484.18 ACCEPTANCE OF PATIENTS, POC, | G 158 | | 3/31/10 |

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| G 158 | Continued From page 3<br>MED SUPER | G 158 | | |

Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.

This STANDARD is not met as evidenced by:
Based on record review and interview, the facility failed to ensure the patient's care plan was followed for 1 of 15 patients (Patient #4), and failed to alert the physician of missed visits for 2 of 15 patients (Patient #2, #7).

Findings include:

Patient #4

Patient #4 was admitted to the agency on 1/2/10 with diagnoses including pressure ulcers, Stage II and III, hypothyroidism, hypertension, congestive heart failure and depression. The resident lived in an assisted living facility.

The physician's orders include:
- SN (Skilled Nurse) to assess/observe and/or instruct Pt(Patient)/CG (Caregiver): Cardiac Status
- Notify Physician of:
  Systolic > 150 or < 100
  Diastolic >90 or <50
  Pulse > 100 or < 52
- SN to assess and instruct/observe in Management of disease process to include: HTN (Hypertension), s/s (signs and symptoms) of Infection, Hypotension Episodes, Bradycardia, Wound care.

Patient #4's nursing notes dated 1/4/10 indicated

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| G 158 | Continued From page 4 | G 158 | | |

" Pulse 55 - 48, Bradycardia. Dr. xxx notified re: cardiac concerns . Work up for Pacer (Pacemaker) will be initiated next GP (General Practitioner) visit..."

Additional nurse's notes revealed:
- 1/05/10 Pulse 30 - 54; "Vascillating dysrhythmia";
- 1/08/10 Pulse 31 - 53; "dropped beat every 3rd beat";
- 1/09/10 Pulse 43 - 48;
- 1/21/10 Pulse 44 - 62; "Bradycardia"
- 1/22/10 Pulse 90 - 43; S1 - S2 (Sinus 1, Sinus 2) with Mobitz (heart block) to Bradycardia;
- 1/27/10 Pulse 32; "Brady (bradycardia) with flux to recovery."

There was no documented evidence the physician was notified of Resident #4's episodes of bradycardia for the above dates.

In the afternoon of 1/29/10, the skilled nurse (SN) indicated she did not always call the physician when Patient #4 had bradycardia since the physician was aware of the patient's medical problem. The SN indicated the patient required a pacemaker but the patient decided not to have the procedure.

There was no documentation in the medical record that the patient had the evaluation for the pacemaker and subsequently refused the procedure.

Patient #2

Patient #2 was admitted to the agency on 9/1/09 with diagnoses including Cellulitis of the Leg, Colostomy, Hypertension and DJD (Degenerative

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| G 158 | Continued From page 5<br>Disk Disease) of the Spine.<br><br>Patient #2's physician's orders included:<br>- 10/24/09 - "Levaquin 250 mg (milligrams)/50 cc (cubic centimeters) D5W (5% Dextrose in Water) via peripheral line QD (every day) x 10 days. Last dose on 11/2/2009..."<br>- 10/31/09 - "IV (Intravenous) antibiotics with Levaquin at same dose to continue up to 11/5/09 as last dose."<br><br>There was no documented evidence of a SN (skilled nurse) visit on 11/4/09 for the administration of the antibiotic. There was no documented evidence the physician was notified of the missed visit and the missed dose of the IV antibiotic, Levaquin.<br><br>In the afternoon of 1/29/09, the Acting Director of Nurses confirmed there were no nurse's notes or missed visit report for 11/4/09.<br><br>Patient #7<br><br>Patient # 7 was admitted to the agency on 6/14/09 with diagnoses including DMII (Diabetes Mellitus Type II), Mixed Ulcer of the Calf, Hypertension and Anemia.<br><br>During the certification period 12/11/09 to 2/8/10, the plan of care included SN (skilled nurse) visits every day for wound care to the right leg ulcer.<br><br>Documentation in the medical record revealed a missed visit report dated 12/21/09 which indicated the patient/family cancelled the visit due to a family emergency. The section which indicated the physician was notified was left blank. | G 158 | | |

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| G 158 | Continued From page 6<br>Documentation in the medical record revealed a missed visit report dated 1/25/10 which indicated there was no answer at the door or by telephone. The section which indicated the physician was notified was left blank.<br><br>On 1/28/10 in the afternoon, the Acting Director of Nurses confirmed there was no documentation in the medical record that the physician was notified of the 2 missed visits. | G 158 | | |
| G 165 | 484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS<br><br>Drugs and treatments are administered by agency staff only as ordered by the physician.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure medications were administered according to physician orders for 2 of 15 patients (Patient #2, #6).<br><br>Findings include:<br><br>Patient #2<br><br>Patient #2 was admitted to the agency on 9/1/09 with diagnoses including Cellulitis of the Leg, Colostomy, Hypertension and DJD (Degenerative Disk Disease) of the Spine.<br><br>Patient #2's physician's orders included:<br>- 10/24/09 - "Levaquin 250 mg (milligrams)/50 cc (cubic centimeters) D5W (5% Dextrose in Water) via peripheral line QD (every day) x 10 days. Last dose on 11/2/2009..."<br>- 10/31/09 - "IV (Intravenous) antibiotics with Levaquin at same dose to continue up to 11/5/09 | G 165 | | 3/31/10 |

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| G 165 | Continued From page 7<br>as last dose."<br><br>There was no documented evidence of a SN (skilled nurse) visit on 11/4/09 for the administration of the IV antibiotic.<br><br>In the afternoon of 1/29/09, the Acting Director of Nurses confirmed there was no nurse's notes for the planned visit of 11/4/09. There was no documented evidence the IV antibiotic, Levaquin was administered.<br><br>Patient #6<br><br>Patient #6 was a 73 year old male admitted to the agency on 1/9/10 with diagnoses including DMI (Diabetes Mellitus Type I), Congestive heart Failure, Hypertension, Bilateral Amputation of Legs.<br><br>Patient #6's plan of care included the following orders:<br>- " Lantus insulin 55 units sq (subcutaneously) qhs (every night)"<br>- " Novolin R (Regular) s/s (sliding scale) per patient > 100 mg(milligram)/dl (deciliter) 8 units sq (subcutaneously) then increase dose by 5 units/100 mg/dl"<br>- "Glucometer testing to be done by patient qid (four times a day)"<br><br>During the home visit on 1/27/10, the skilled nurse indicated the patient's blood sugar was tested during the SN visit. However, the patient monitored his BS and gave himself the sliding scale insulin. The SN did not know the frequency or dosage of s/s Insulin to be administered.<br><br>During the home visit on 1/27/10, Patient #6 | G 165 | | |

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| G 165 | Continued From page 8<br>indicated he checked his BS and gave the s/s Novolin insulin coverage as followed:<br>- For a BS > 100 mg/dc he used 5 U Novolin Insulin;<br>- For a BS of 250mg/dc, he would use 7.5 U of Novolin Insulin<br><br>There was no order which indicated the frequency of administration of the s/s insulin.<br>The s/s insulin dosage as described by the patient, does not correspond to the physician's orders. There was no documented evidence the SN called the physician to clarify the s/s insulin orders. | G 165 | | |
| G 337 | 484.55(c) DRUG REGIMEN REVIEW<br><br>The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.<br><br>This STANDARD is not met as evidenced by:<br>Based on interview and record review, the agency failed for one of 15 sampled patients to review all medications the patient was currently using to identify any potential adverse effects and drug reactions including ineffective drug therapy, significant side effects, significant drug interactions and duplicate drug therapy (Patient #12).<br><br>Findings include:<br><br>Patient #12<br><br>Patient #12's record was reviewed on 2/3/10. | G 337 | | 3/31/10 |

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| G 337 | Continued From page 9<br>Patient #12 was admitted to the agency on 10/7/09, with diagnosis including abnormality of gait, Alzheimer's disease, and cancer of the lung.<br><br>A review of the Medication Profile (MP) form for Patient #12 revealed a licensed nurse had recorded the name of the medication, the dose and route of the medication, the frequency of the medication, and the purpose of the medication for the 14 medications currently used by Patient #12. The lines for potential side effects of each of the 14 medications were blank. It was noted that on the back of the MP were numbers which corresponded to drug classifications with the potential side effects printed for each classification.<br><br>An interview was held with the ADPCS (Acting Director of Patient Care Services) on 2/3/10, at 2:10 p.m. The ADPCS stated when the nurse recorded the medication on the MP, the nurse should look for the number of the classification for that medication and record the classification number on the MP in the column for potential side effects.<br><br>The agency's undated policy titled "C-700 Medication Profile/Drug Regimen Review" read, "3. The medication profile shall document...G. Medication actions and side effects...J. Drug or food-drug interactions." | G 337 | | |